CITY OF ALAMO
CERTIFICATE OF ABSENCE

THIS FORM SHALL BE COMPLETED AND APPROVED PRIOR TO THE DATE OF ANTICIPATED ABSENCE. ALLOW FIVE (5) DAYS LEAD TIME, IN THE EVENT OF AN ILLNESS OR EMERGENCY WHICH PRECLUDES PRIOR COMPLETION OF THIS FORM, THE EMPLOYEE SHOULD CALL HIS/ HER SUPERVISOR. THIS FORM MUST BE COMPLETED AS SOON AS THE EMPLOYEE RETURNS TO WORK. *A DOCTOR'S STATEMENT MUST BE ATTACHED* IF ILLNESS IS FOR TWO (2) OR MORE CONSECUTIVE DAYS.

SECTION I. TO BE COMPLETED BY THE EMPLOYEE

NAME: _____ EMP NO#_____ DATE: _____

DATE OF ABSENCE: _____

_____ILLNESS _____EMERGENCY (SPECIFY)

_____VACATION _____COMP TIME _____OTHER (SPECIFY)

CHOOSE ONLY ONE OF THE FOLLOWING:

_____WITH PAY _____WITHOUT PAY

COMMENTS: _____

_____

_____ _____
DEPT. HEAD/SUPR. (Prior Approval) SIGNATURE OF EMPLOYEE

DATE _____ DATE _____

SECTION II. TO BE COMPLETED BY PERSONNEL

_____ WITH PAY _____WITHOUT PAY

COMMENTS: _____

_____
SIGNATURE DATE _____

SECTION III. TO BE COMPLETED BY CITY MANAGER

RECOMMEND APPROVAL_____ RECOMMEND DISAPPROVAL_____

REASON IF DISAPPROVED _____

CITY MANAGER_____ DATE_____

REV/5/02